	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,			A. BUILDING: _			
		MHL063-089	B. WING		R 03/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LINDEN L	ODGE	2251 LIND	EN ROAD N, NC 28315			
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	l (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
		-up survey was completed deficiencies were cited.				
	category: 10A NCAC	d for the following service 27G. 5600A Adults with Mental Illness				
	census of 6.	d for 6 and currently has a				
	The survey sample co current clients.	onsisted of audits of 3				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	10A NCAC 27G .020 TREATMENT/HABILI PLAN	5 ASSESSMENT AND TATION OR SERVICE				
	(c) The plan shall be assessment, and in p	developed based on the artnership with the client or				
	of admission for clien receive services beyo					
	(d) The plan shall inc(1) client outcome(s)achieved by provision) that are anticipated to be				
	projected date of ach (2) strategies;	ievement;				
		; view of the plan at least on with the client or legally				
	responsible person of (5) basis for evaluatioutcome achievement	on or assessment of				
	(6) written consent or responsible party, or	or agreement by the client or a written statement by the				
	provider stating why sobtained.	such consent could not be				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R	
		MHL063-089	B. WING		03/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LINDEN L	ODGE	2251 LIND	EN ROAD			
LINDLINE		ABERDEE	N, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE COMPLETE	
V 112			V 112			
	failed to develop a tre of admission affecting (#1) and failed to dev	ew and interview, the facility eatment plan within 30 days gone of three audited clients elop a current treatment hree audited clients (#2 and				
	-Admission date of 1/ -Diagnoses of Schizo Personality Disorder, Mixed Hyperlipidemia -No evidence of a trea of client's admission of	affective Disorder, Mixed Dissociative Disorder, and Hypertension. atment plan within 30 days				
	-Admission date of 4/ -Diagnoses of Schizo	affective Disorder, Bipolar Compulsive Disorder. ed 11/2023.				
	-Admission date of 6/ -Diagnoses of Schizo	affective Disorder, Bipolar Hyperlipidemia, and Other red 11/2023.				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 2 of 12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
					R
		MHL063-089	B. WING		03/26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
LINDEN L	ODGE		DEN ROAD		
			EN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 112	Continued From page	2	V 112		
	revealed: -He would be respons treatment plans were timely mannerPending the hire of a	with the Executive Director sible for ensuring clients' current and completed in a Qualified Professional, that onsible for completing the			
V 536	27E .0107 Client Right Int.	ts - Training on Alt to Rest.	V 536		
	to restrictive intervent (b) Prior to providing disabilities, staff include employees, students demonstrate compete completing training in other strategies for cru which the likelihood o or injury to a person w property damage is per (c) Provider agencies based on state compe compliance and demon gathered. (d) The training shall i include measurable le measurable testing (w behavior) on those ob methods to determine course.	plement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall noce by successfully communication skills and eating an environment in fimminent danger of abuse with disabilities or others or revented. It is shall establish training etencies, monitor for internal constrate they acted on data the competency-based, earning objectives, written and by observation of jectives and measurable			

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 3 of 12

Division	of Health Service Regu	liation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			B WING		R	
		MHL063-089	D. WING		03/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			DEN ROAD	·		
LINDEN L	ODGE					
		ABERDE	EN, NC 28315			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-/	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
IAG	REGOLATOR OTT	EGG IBERTII TING IIN GRAWATION,	TAG	DEFICIENCY)	W. (1) E	
V 536	Continued From page	e 3	V 536			
	by each contine provi	der periodically (minimum				
		der periodically (minimum				
	annually).					
	(f) Content of the train	•				
		nploy must be approved by				
	the Division of MH/DI	•				
	Paragraph (g) of this					
		strate competence in the				
	following core areas:					
		and understanding of the				
	people being served;					
	(2) recognizing	and interpreting human				
	behavior;					
		the effect of internal and				
	external stressors that	at may affect people with				
	disabilities;					
	(4) strategies for	or building positive				
	relationships with per	sons with disabilities;				
	(5) recognizing	cultural, environmental and				
	organizational factors	that may affect people with				
	disabilities;					
	(6) recognizing	the importance of and				
	assisting in the perso	n's involvement in making				
	decisions about their	life;				
	(7) skills in ass	essing individual risk for				
	escalating behavior;					
	(8) communica	tion strategies for defusing				
	and de-escalating po	tentially dangerous behavior;				
	and					
	(9) positive bel	navioral supports (providing				
		h disabilities to choose				
	activities which direct					
	behaviors which are					
	(h) Service providers					
	` '	ial and refresher training for				
	at least three years.					
	_	tion shall include:				
	() =	ated in the training and the				
	outcomes (pass/fail);	atos in the training and the				
		vhere they attended; and				
	(B) when and v	viicie iliey allenueu, and				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 4 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B MING		R		
	MHL063-089	B. WING		03/2	6/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
LINDEN LODGE	2251 LIND	EN ROAD				
LINDEN LODGE	ABERDEE	N, NC 28315				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 536 Continued From pag	e 4	V 536				
(C) instructor's (2) The Division review/request this dinibitation (i) Instructor Qualification Requirements: (1) Trainers ship y scoring 100% on a aimed at preventing, need for restrictive in (2) Trainers ship y scoring a passing instructor training profession (3) The training competency-based, in objectives, measurable methods failing the course. (4) The contenservice provider plans approved by the Divito Subparagraph (i)(sing (5)) Acceptable shall include but are (A) understand (B) methods for course; (C) methods for course; (C) methods for performance; and (D) documentation (6) Trainers ship teaching a training pureducing and eliminating interventions at least review by the coach. (7) Trainers ship aimed at preventing,	name; n of MH/DD/SAS may ocumentation at any time. ations and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an ogram. g shall be nclude measurable learning ble testing (written and by ior) on those objectives and to determine passing or t of the instructor training the s to employ shall be sion of MH/DD/SAS pursuant	V 330				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 5 of 12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		R	
		MHL063-089	B. WING		03/26/202	24
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LINDEN L	ODGE	2251 LINDE				
			N, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
V 536	instructor training at le (j) Service providers documentation of initi training for at least the (1) Docume (A) Who particip outcomes (pass/fail); (B) When and W (C) instructor's (2) The Division request and review th (k) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh the course which is be (3) Coaches sh competence by comp train-the-trainer instru (I) Documentation sh as for trainers. This Rule is not met Based on record revie failed to ensure one of	all complete a refresher east every two years. shall maintain al and refresher instructor ree years. entation shall include: ated in the training and the where attended; and name. In of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation iner. hall teach at least three times eing coached. hall demonstrate eletion of coaching or action. hall be the same preparation hall be the same preparation hall be the same preparation where the same preparation hall be the same preparation as evidenced by: where and interview, the facility of two audited staff (#1)	V 536			
	Director received the the use of alternatives. The findings are:	ining and the Executive annual update trainings on s to restrictive interventions. Staff #1's personnel record				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 6 of 12

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
						R
		MHL063-089	B. WING		03	/26/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
LINDEN L	ODGE		IDEN ROAD EEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 536	revealed: -Hired date of 12/18/2 -Title: Direct Support -There was no evider Crisis Intervention Planired. Review on 3/26/24 of personnel record reventied date of 7/26/2 -NCI+ training expiredupdate training in the Interview on 3/26/24 revealed: -He would be respondensuring all staff recentaringsHe would schedule to	Professional on 3rd shift. Ince of the initial National Ius (NCI+) training since If the Executive Director's Iterational events and the initial NCI+ Ince of the annual NCI+ Ince of the annual NCI+ Ince of the Executive Director Insible for monitoring and Ince of NCI + initial and yearly Iterational events are initial and staff #1. Ince of the annual NCI+ Ince of the Executive Director	V 536			
V 537	10A NCAC 27E .0103 SECLUSION, PHYSI ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to en procedures are retrai competence at least	CAL RESTRAINT AND UT cal restraint and isolation bloyed only by staff who have we demonstrated roper use of and alternatives Facilities shall ensure that inploy and terminate these ned and have demonstrated	V 537			

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 7 of 12

DIVISION	of Health Service Regu	llation			<u>, </u>	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
			1			
			B. WING		R	
		MHL063-089	D. WING		03/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			DEN ROAD			
LINDEN L	ODGE		EN, NC 28315			
		ABERDE	EN, NC 20315			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(-/	
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	REGOLATORT ORT	EGG IDEIVIII TING INI ONWATION)	TAG	DEFICIENCY)	TOPATE	
V 537	Continued From page	e 7	V 537			
	-11:1:11:41:4	- 4 4.// In :11:4 - 4: I				
		atment/habilitation plan				
		terventions, staff including				
	service providers, em					
	•	olete training in the use of				
		estraint and isolation time-out				
		se interventions until the				
	training is completed	and competence is				
	demonstrated.					
	(c) A pre-requisite fo	r taking this training is				
	demonstrating compe	etence by completion of				
	training in preventing	, reducing and eliminating				
	the need for restrictiv	e interventions.				
	(d) The training shall	be competency-based,				
	include measurable le					
		written and by observation of				
	- ,	ojectives and measurable				
	•	e passing or failing the				
	course.	passing or railing and				
		training must be completed				
		der periodically (minimum				
	annually).	der periodically (minimali				
	(f) Content of the trai	ining that the service				
		ploy must be approved by				
	the Division of MH/DI					
	Paragraph (g) of this	•				
	0 1 (0)	ng programs shall include,				
	but are not limited to,					
	` '	formation on alternatives to				
	the use of restrictive i	•				
		on when to intervene				
		nent danger to self and				
	others);					
		n safety and respect for the				
		all persons involved (using				
	-	trictive interventions and				
	incremental steps in a					
	(4) strategies for	or the safe implementation				
	of restrictive intervent	tions;				
	(5) the use of e	emergency safety				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 8 of 12

DIVISION	n nealth Service Regu	lation				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	CORRECTION IDENTIFICATION NUMBER:			COMPLI	ETED
					_	<u> </u>
			B. WING		F	
		MHL063-089	B. WING		03/2	6/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2251 LIND	EN ROAD			
LINDEN L	ODGE		N, NC 28315			
			N, NC 20315			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG	TREGOLD TOTAL OTTE	iso is a river in the state of	TAG	DEFICIENCY)	W (1 L	
V 537	Continued From page	e 8	V 537			
	interventions which in	voludo continuous				
		itoring of the physical and				
		ing of the client and the safe				
		ghout the duration of the				
	restrictive intervention					
	(6) prohibited p					
		trategies, including their				
	importance and purpo					
	(8) documentat	tion methods/procedures.				
	(h) Service providers	shall maintain				
	documentation of initi	al and refresher training for				
	at least three years.					
	(1) Documenta	tion shall include:				
	(A) who particip	ated in the training and the				
	outcomes (pass/fail);					
	(B) when and w	vhere they attended; and				
	(C) instructor's	-				
		n of MH/DD/SAS may				
		ocumentation at any time.				
	(i) Instructor Qualifica					
	Requirements:	3				
	•	all demonstrate competence				
	` '	esting in a training program				
		reducing and eliminating the				
	need for restrictive int	-				
		all demonstrate competence				
		esting in a training program				
	-					
	and isolation time-out	eclusion, physical restraint				
	• •	all demonstrate competence				
		grade on testing in an				
	instructor training pro	<u> </u>				
	(4) The training					
		nclude measurable learning				
		le testing (written and by				
		or) on those objectives and				
		to determine passing or				
	failing the course.					
	(5) The content	t of the instructor training the				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 9 of 12

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING		R	
		MHL063-089	B. WING		03/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			EN ROAD	,		
LINDEN L	ODGE					
		ABERDE	N, NC 28315			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	MAIE DAIL	
			+			
V 537	Continued From page	9	V 537			
	. •					
	service provider plans					
		ion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6) of this Rule.				
	(6) Acceptable	instructor training programs				
	shall include, but not	be limited to, presentation				
	of:					
	(A) understandi	ng the adult learner;				
		teaching content of the				
	course;					
	*	of trainee performance; and				
	` '	ion procedures.				
		all be retrained at least				
	` '					
		trate competence in the use				
		restraint and isolation				
	-	in Paragraph (a) of this				
	Rule.					
	• •	all be currently trained in				
	CPR.					
		all have coached experience				
	_	restrictive interventions at				
	least two times with a	positive review by the				
	coach.					
	(10) Trainers sha	all teach a program on the				
	use of restrictive inter	ventions at least once				
	annually.					
	(11) Trainers sha	all complete a refresher				
	instructor training at le					
	(k) Service providers	•				
		al and refresher instructor				
	training for at least the					
	_	tion shall include:				
	()	ated in the training and the				
	outcome (pass/fail);	atos in the daming and the				
	***	here they attended; and				
	(C) instructor's					
	` '	n of MH/DD/SAS may				
		ocumentation at any time.				
	(I) Qualifications of C					
	(1) Chaches sh	all meet all preparation	1			

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 10 of 12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL063-089	B. WING		R 03/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LINDEN L	ODGE	2251 LINDI				
			N, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 10	V 537			
	requirements as a tra (2) Coaches sh times, the course whi	iner. call teach at least three ch is being coached. call demonstrate letion of coaching or ction. chall be the same				
	facility failed to ensure (#1) received the initial Director received the seclusion, physical retime-out. The findings Review on 3/26/24 of revealed: -Hired date of 12/18/2-Title: Direct Support -There was no eviden	ews and interviews, the e one of two audited staff al training and the Executive annual training updates in straint and isolation s are: Staff #1's personnel record 23. Professional on 3rd shift. ace of the initial National				
	hired. Review on 3/26/24 of personnel record reversities date of 7/26/21 -NCI+ training expired -There was no evider update training in the	l. d 12/2023. ice of the annual NCI+				
		sible for monitoring and				

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 11 of 12

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Division of Health Service Regulation

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MHL063-089 B. WING 03/	26/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LINDEN LODGE 2251 LINDEN ROAD ABERDEEN, NC 28315	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 537 Continued From page 11 V 537	
ensuring all staff received NCI + initial and yearly trainings. -I-le would schedule training for him and staff #1NCI+ training included the hold techniques.	

Division of Health Service Regulation

STATE FORM 6899 L4GC11 If continuation sheet 12 of 12